Handbook for Providers of Medical Equipment and Supplies

Chapter M-200
Policy and Procedures for Medical Equipment and Supplies

Illinois Department of Public Aid

CHAPTER M-200

DURABLE MEDICAL EQUIPMENT AND SUPPLIES

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FOREWORD

PURPOSE

This handbook has been prepared for the information and guidance of durable medical equipment and medical supply providers who provide items or services to participants in the Department's Medical Programs. Contained in this handbook are both policy and procedures for durable medical equipment and medical supply items and services. This handbook provides information on which items require prior approval and how to obtain prior approval.

Providers will be held responsible for compliance with all policy and procedures contained herein.

CHAPTER M-200

DURABLE MEDICAL EQUIPMENT MEDICAL SUPPLIES

M-200 BASIC PROVISIONS

For consideration for payment by the Department for medical equipment or medical supply items or services, such items or services must be provided by a provider enrolled for participation in the Department's Medical Programs. The items or services must be provided in full compliance with both the general provisions contained in the Handbook for Providers of Medical Services, Chapter 100 General Policy and Procedures and the policy and procedure contained in this handbook. Exclusions and limitations are identified in the specific topics contained herein.

M-201 PROVIDER PARTICIPATION

M-201.1 PARTICIPATION REQUIREMENTS

Eligible providers are those who supply or service nondurable medical supplies, durable medical and respiratory equipment, prostheses, orthoses, oxygen and hearing aids.

In order to be eligible for reimbursement for dispensing certain sophisticated medical devices or items, a provider must be licensed or exempt from licensure under the Home Medical Equipment and Services Provider License Act, 225 ILCS 51. Providers located in other states must also be in compliance with the appropriate licensing or accreditation requirements of their state of practice.

Audiologists who dispense hearing aids, Long Term Care (LTC) facilities that dispense oxygen and hospitals should consult their respective handbooks for participation requirements. Providers in these licensure categories may need to specifically request that their enrollment include approval to dispense medical equipment and supplies.

The provider must be enrolled for the specific category of services for which charges are to be made.

The categories of service for which a provider may enroll are:

- Category 41, Medical Equipment/Prosthetic Devices
- Category 48 Medical Supplies

Procedure: The provider must complete and submit:

- Form DPA 2243, Provider Enrollment/Application Form
- Form DPA 1413, Provider Agreement
- W-9 Request for Taxpayer Identification Number

If the provider is licensed, a copy of the license must also be submitted.

These forms are obtained by calling the Provider Participation Unit at (217)782-0538 or by sending a request to:

Illinois Department of Public Aid
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114

E-mail requests for enrollment forms should be addressed to:
PPU@mail.idpa.state.il.us

The original of each form must be completed (printed in ink or typewritten) and signed and dated in ink and returned to the Department. A copy is to be retained by the provider. The date on the application will be the effective date of enrollment unless the provider requests a specific enrollment date and it is approved by the Department.

Further information on enrollment and participation requirements can be found in Handbook for Providers of Medical Services, Chapter 100 General Policy and Procedures, Topic 101.1.

M-201.2 PARTICIPATION APPROVAL

When participation is approved, the provider will receive a computer-generated notification, the Provider Information Sheet, listing all data on the Department's computer files. The provider is to review this information for accuracy immediately upon receipt. For an explanation of the entries on the form, see Appendix M-3.

If all information is correct, the provider is to retain the Provider Information Sheet for subsequent use in completing claims (billing statements) to ensure that all identifying information required is an exact match to that in the Department files. If any of the information is incorrect, refer to Topic M-201.4.

M-201.3 PARTICIPATION DENIAL

Written notification to the provider of denial of an application for participation will include the reason for such a determination.

Within 10 days after such notice, the provider may request a hearing. The request must be in writing and must contain a brief statement of the basis on which the Department's action is being challenged. If such a request is not received within 10

days, or is received but later withdrawn, the Department's decision shall be a final and binding administrative determination. Department Rules concerning the bases for denial of participation are set out in 89 Ill.Adm.Code 140.14. Department Rules concerning the administrative hearing process are set out in 89 Ill.Adm.Code 104 Subpart C.

M-201.4 PROVIDER FILE MAINTENANCE

The information carried in Department files for participating providers must be maintained on a current basis. The provider and the Department share responsibility for keeping the file updated.

Provider Responsibility

The information contained on the Provider Information Sheet is that which is carried on Department files. Each time the provider receives a Provider Information Sheet, it is to be reviewed carefully for accuracy. The Provider Information Sheet contains information to be used by the provider in the preparation of claims; any inaccuracies found are to be corrected and the Department notified immediately.

Any time the provider effects a change that causes information on the Provider Information Sheet to become invalid, the Department is to be notified. When possible, notification should be made in advance of a change.

Failure of the provider to properly notify the Department of corrections or changes may cause an interruption in participation and payments.

Procedure: The provider is to line out the incorrect or changed data, enter the correct data and sign the Provider Information Sheet with an original signature on the line provided. Forward the corrected Provider Information Sheet to:

Illinois Department of Public Aid
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114

Department Responsibility

Whenever there is any change in the provider's enrollment status or any change submitted by the provider, an updated Provider Information Sheet will be generated indicating the change and the effective date.

M-202 MEDICAL EQUIPMENT AND SUPPLIES REIMBURSEMENT

When billing for services or materials, the claim submitted for payment must include a diagnosis and the coding must reflect the actual services provided and the materials dispensed. Any payment received from a third-party payer, a program participant or other persons applicable to the provision of services must be reflected as a credit on any claim submitted to the Department bearing charges for those services or items. (Exception: KidCare co-payments are not to be reflected on the claim. Refer to Topic 114.1 for more information on KidCare co-payments.)

> There are to be no arrangements to furnish more costly products, such as an electric wheelchair instead of a standard wheelchair or pull-ups instead of diapers, with the patient supplementing charges made to the Department.

Reimbursement for a custom-fabricated item is limited to those items which are manufactured specifically for a single patient (for example, from a molding process) or which are modified by molding or altering the basic construction of a standard item to conform to a patient's deformity. Measuring and custom-fitting an item to a patient, or custom-assembling an item to fit a patient's needs using stock pieces does not qualify for billing as a custom-fabricated item. Unusual sizes do not routinely qualify an item for reimbursement as a custom item.

The Department's allowable maximum reimbursement rates for the purchase or rental of most items are listed on the Department's website. Separate listings are provided for Durable Medical Equipment, Prostheses/Orthoses and Medical Supplies. For each category, there is an alphabetical listing by product and a numerical listing by HCPCS code. The listings also identify the Department's normal quantity limitations on each item, whether the item is covered for residents of Long Term Care facilities and whether it requires prior approval. The listings can be found at http://www.dpaillinois.com/reimbursement/

Paper copies of the listings can be obtained by sending a written request to:

Illinois Department of Public Aid
Bureau of Comprehensive Health Services
DME Billing Unit
201 South Grand Avenue East
Springfield, IL 62763-0001

The maximum rates, quantity limitation and prior approval requirements for each item are also available electronically. The Department maintains a downloadable

rate file suitable for use in updating a provider's computerized billing system. This file is located in the same area on the Department's website as the alphabetical and numerical listings described above. A copy of this file can also be obtained by sending a blank 3.5 inch IBM PC compatible diskette, a written request and a self-addressed, prepaid diskette mailer to the address listed above.

The website listings and the downloadable rate file are updated quarterly. Providers will be advised of major changes via a written notice. Provider notices will not be mailed for minor updates such as error corrections or the addition of newly created HCPCS codes.

M-202.1 CHARGES

Charges billed to the Department are to be the provider's usual and customary charges to the general public for the items provided.

NOTE: No separate additional charge is to be made for freight, postage, delivery, installation, set-up, instruction, fitting, adjustments, measurement, demurrage, facility visits or transportation, since these services are considered to be all-inclusive in a provider's charge for the item or service requested.

M-202.11 Charges For Replacement Items

Replacements of previously purchased items are subject to all policies that apply to an original purchase, except as described in Topic M-210.5.

Under no circumstances can charges be billed for replacement of an item which is under warranty unless the provider can submit proof that the reason for replacement is not covered under the warranty (for example, if the item was destroyed in a fire).

M-202.12 Charges For Repair Services

Repair charges are to be billed under the appropriate procedure code for the item being repaired. An itemized breakdown of the repair charges must be attached to the claim.

Repair charges for items which are under warranty are not covered without prior approval. If the warranty covers a portion of the costs (for example, parts but not labor), the request for prior approval and the itemized breakdown of repair charges must show all the costs and clearly indicate which costs are covered under warranty and which will be billed to the Department.

If it is the provider's usual and customary practice to furnish and charge for a loaner

item pending the completion of repairs, the loaner item may be provided without prior approval. Charges for the loaner item are to be submitted under the appropriate procedure code for the item furnished. Reimbursement for loaner items will be a one-time charge and may not exceed the Department's established rate for a one-month rental of the same item. Refer to Appendix M-1 for billing instructions.

M-202.2 ELECTRONIC CLAIMS SUBMITTAL

Any services which do not require attachments or accompanying documentation may be billed electronically. Further information can be found in Handbook for Providers of Medical Services, Chapter 100 General Policy and Procedures, Topic 112.3.

> Providers billing electronically should take special note of the requirement that Form DPA 194-M-C, Billing Certification Form, must be signed and retained for a period of three years. Failure to do so may result in revocation of the provider's right to bill electronically, recovery of monies or other adverse actions. Form DPA 194-M-C can be found on the last page of each Remittance Advice which reports the disposition of any electronic claims. Refer to Handbook for Providers of Medical Services, Chapter 100 General Policy and Procedures, Topic 130.5 for further details.

The specifications for electronic claims billing are similar to, but not the same as, those for paper claims. Please follow the instructions for the media being used. If a problem occurs with electronic billing, the provider should contact the Department in the same manner as would be applicable to a paper claim. It may be necessary for the provider to contact his software vendor if the Department determines that the claim rejections are being caused by the submission of incorrect or invalid data.

M-202.3 CLAIM PREPARATION AND SUBMITTAL

See Handbook for Providers of Medical Services, Chapter 100 General Policy and Procedures, Topic 112, for general policy and procedures regarding claim submittal. For general information on billing for Medicare covered services and submittal of claims for participants eligible for Medicare Part B, see Handbook for Providers of Medical Services, Chapter 100 General Policy and Procedures, Topic 120.1.

Form DPA 2210, Medical Equipment/Supplies Invoice, is to be used to submit charges. A copy of the form and detailed instructions for its completion are included in Appendices M-1 and M-1a. For specific instructions for preparing claims for Medicare covered services, refer to Appendix M-1b.

All routine paper claims (claims without any attachments) are to be submitted in Form DPA 1444, Provider Invoice Envelope, a preaddressed mailing envelope

provided by the Department for this purpose. Use of this preaddressed envelope should ensure that claims will be properly routed for processing.

A second type of preaddressed envelope, Form DPA 2248, Special Handling Envelope, is to be used for mailing nonroutine claims. A nonroutine claim is a claim to which any document is attached.

For electronic claims submittal, see Topic M-202.2 above and Handbook for Providers of Medical Services, Chapter 100 General Policy and Procedures, Topic 112.3. Non-routine claims may not be electronically submitted.

M-202.4 PAYMENT

Payment made by the Department for allowable items or services provided to participants will be no more than the provider's usual and customary fees. The payment made is the lesser of the provider's charge or the maximum established by the Department for the item or service.

M-203 COVERED SERVICES

A covered service is an item or service for which payment can be made. The services covered in the program include only those reasonably necessary medical and remedial services which are recognized as standard medical care required for immediate health and well-being because of illness, disability, infirmity or impairment.

> Certain services and materials are covered only when provided in accordance with the limitations and requirements described in the individual topics within this handbook.

A written recommendation (order) or plan of care signed and dated by the patient's physician is required for the provision of medical supplies and equipment. Either electronic or handwritten dates are acceptable. Orders transmitted by telefax are acceptable, provided it is clear from the contents that the physician personally signed the original order. Multiple page orders must have the patient's name on every page.

Orders with signature stamps or on which the physician's name was signed and initialed by a nurse are not accepted by the Department as valid physician orders. A plan of treatment by a home health agency is not accepted by the Department as a valid physician order for medical equipment and supplies.

A podiatrist's order for items required for care of the foot or ankle will be accepted, subject to the same restrictions and policies as a physician's order.

Items ordered by an advanced practice nurse, pursuant to a current written collaborative or practice agreement required by the Nursing and Advanced Practice Nursing Act [225 ILCS 65] and implementing rules (68 Ill. Adm. Code 1300), will be covered to the extent that the item would be covered if it were ordered by a physician. All orders written and signed by advanced practice nurses must indicate their credentials as well as the name of the collaborating physician.

Items ordered by a physician assistant, pursuant to written guidelines required by the Physician Assistant Practice Act of 1987 [225 ILCS 95] and implementing rules (68 Ill. Adm. Code 1350), will be covered to the extent that the item would be covered if it were ordered by a physician. All orders written and signed by physician assistants must indicate their credentials as well as the name of the supervising physician.

A prescription signed by a pharmacist will be accepted for medical supplies and non-durable equipment, provided the signing pharmacist received the contents as a verbal order from the physician whose name is being used on the prescription. A copy of the prescription must be retained by the pharmacy.

Coverage is limited to those items which are specifically included in the physician's written order. Items which are added to the order by the supplying provider will not be covered unless a supplemental order is signed by the physician.

The following general types of services are covered, subject to the limitations described in this handbook:

Nondurable Medical Supplies - Items which have a limited life expectancy, including but not limited to surgical dressings, bandages, disposable syringes, etc. These items are used for an individual's care for life maintenance or to expedite hospital discharge and enable the person to be cared for at home.

Durable Medical Equipment - Items which can withstand repeated use, are primarily designed for medical purposes, generally not useful in the absence of illness or injury and appropriate for use in the home.

Prostheses and Orthoses - Corrective or supportive devices prescribed to artificially replace a missing portion of the body or to prevent or correct physical deformity or malfunction, or to support a weak or deformed portion of the body.

Respiratory Equipment and Supplies - Respiratory items, including oxygen, necessary as a life saving measure, for prevention of a medical emergency or institutionalization, or to facilitate deinstitutionalization.

Repair, Alterations and Maintenance - Repair, alteration and maintenance of necessary durable medical equipment, prostheses, orthoses and hearing aids is limited to patient-owned items.

Rental of Medical Equipment - Under certain circumstances, such as when a patient's need is known to be temporary, coverage will be for rental rather than purchase of an item.

Monaural or binaural hearing aids required to improve or correct a hearing deficit are a covered service. Refer to the Handbook for Audiology Services for policies on coverage and prior approval for hearing aids.

Eyeglasses and other devices to correct vision are a covered service. Refer to the Handbook for Optometric Services for policies on coverage and limitations.

Refer to Handbook for Providers of Medical Services, Chapter 100 General Policy and Procedures, Foreword, for instructions on obtaining copies of handbooks.

Any question a provider may have about coverage of a particular service or item is to be directed to the Department prior to the provision of the service. Providers may call the Bureau of Comprehensive Health Services at (217)782-5565.

M-204 SERVICES NOT COVERED

Services for which medical necessity is not clearly established are not covered in the Department's Medical Programs. Also see Handbook for Providers of Medical Services, Chapter 100 General Policy and Procedures, Topic 104 for a list of services and items for which payment will not be made.

Payment cannot be made by the Department to providers of medical equipment or supplies for the following:

- Items or services ordered by terminated or barred providers
- Items or services provided for the convenience of patients or their families for which medical necessity is not clearly established
- Items or services inappropriate for the patient's medical condition
- Items or services covered by another agency
- Items or services that require prior approval but for which Department approval has not been obtained
- Disposable items, when a permanent equivalent exists
- Prepackaged "kits" when components are available in bulk
- Stock orthopedic shoes, unless used in conjunction with a brace
- Medical equipment and supplies for residents of Long Term Care facilities except as provided in Topic M-270
- Prostheses inserted or implanted which do not increase physical capacity, overcome a handicap, restore a physiological function, or eliminate a functional disability
- Items or services for a patient in a state mental facility
- Items or services provided as part of a hospital inpatient stay
- Items or services provided as part of a hospital outpatient visit that is billed under the Department's Ambulatory Procedures Listing (APL) coverage
- Items or services fabricated, fitted or dispensed without an appropriate license
- Items or services for a patient receiving hospice care, except as provided in Topic M-210.9
- Any item or service when a less expensive item or service is available and appropriate to meet the patient's need
- Items or services which duplicate other items or services already approved by the Department for the same patient
- Items or services for a patient enrolled in a Managed Care Organization (MCO) such as an HMO

Routine medical supplies which are carried by Home Health Agency staff as they travel from home to home and which are available for use with any of their homebound patients are not separately reimbursable by the Department. Such supplies are considered included in the rate paid to the Home Health Agency.

Medical items or supplies which are ordered by the physician for the Home Health Agency for the continuous care and exclusive use of a single patient are covered items.

Note: Under its prospective payment system, Medicare considers certain medical items or supplies to be the responsibility of the Home Health Agency, even if they are for the exclusive use of a single patient. Such items are not to be separately billed to the Department.

M-205 RECORD REQUIREMENTS

See Handbook for Providers of Medical Services, Chapter 100 General Policy and Procedures, Topic 110 for record requirements applicable to all providers.

For medical equipment and supplies, the basic record must include:

- Current physician's order
- An explanation of the medical necessity for the item or service dispensed, if this is not included in the physician's order
- Clinical diagnoses, if not included in the physician's order
- Patient's name, recipient identification number (RIN) and address
- A record of items and quantities dispensed and the date(s) dispensed, and
- Approved prior authorization requests, if applicable.

Refer to Topic M-203 for further explanation of what constitutes an acceptable physician's order.

In addition, in the case of medical supplies, the provider must be able to document purchases of sufficient quantities of the items to support the volumes dispensed and billed. In the case of durable medical equipment or prostheses, the provider must be able to provide a copy of the original wholesale purchase invoice for the item and records of any customization performed by the provider.

The Department regards the maintenance of adequate records as essential for the delivery of quality medical care. In addition, providers should be aware that medical records are key documents for post-payment audits.

> In the absence of proper and complete records, no payment will be made and payments previously made will be recouped.

M-210 GENERAL LIMITATIONS AND CONSIDERATIONS ON COVERED SERVICES

Except as outlined in Topics M-210.4 and M-210.5, all items may be subject to prior approval by the Department. In addition, items which do not normally require prior approval but which are dispensed in unusually large quantities or with more than normal frequency may also be subject to prior approval. Refer to Topic M-202 for instructions on obtaining listings that identify which items require prior approval and the frequency or quantity limitations for those items that do not normally require prior approval.

For general provisions pertaining to prior approval, see Handbook for Providers of Medical Services, Chapter 100 General Policy and Procedures, Topic 111. For specific procedures to follow to obtain prior approval for medical equipment and supplies, see Topic M-211.

Whether subject to prior approval or not, all items must be ordered by a physician. For further information, refer to Topic M-203. The only exceptions are repairs and temporary rentals to meet the patient's need while an item is being repaired.

All items must be medically necessary and essential and must not exceed health care services received by the general public for similar conditions. There must be a reasonable expectation that the patient will be able to adjust to and use the item and derive benefits from it, in light of his or her medical condition. In instances where more than one type of device or category of supplies are available, the Department will reimburse for the least expensive item that will meet the medical need.

M-210.1 ELIGIBILITY VERIFICATION

Verification of patient eligibility for dates of service is the responsibility of the provider. The provider must see a valid MediPlan or KidCare card or verify patient eligibility through one of the Department's electronic systems or by telephone or fax to assure payment for items or services. For more information on verification of eligibility, see Handbook for Providers of Medical Services, Chapter 100 General Policy and Procedures, Topic 108.

> Prior approval to provide services does not include any determination of the patient's eligibility. When prior approval is given, it is the provider's responsibility to verify the patient's eligibility on the date of service.

In instances where an item is fabricated for the patient, a provider may choose to use either the date the item is fabricated or the date the item is dispensed as the date of service. The Department allows this flexibility in date of service to address concerns about continued eligibility in cases where some time may elapse between fabrication and delivery of an item. This choice must be made at the time the item is fabricated and may not be changed subsequently.

In instances where medical supplies are being provided on a repetitive and ongoing basis, the provider must verify both the patient's continued need for the supplies and the patient's eligibility each time a new supply is delivered.

M-210.2 QUANTITY LIMITATIONS

Whether prior approval is required or not, the quantity of medical supplies will be limited to the amount indicated by the ordering physician or to a reasonable quantity for a month, whichever is less. (Exception: a two-month supply may be dispensed for batteries for hearing aids.) For many items, the Department has established maximum allowable quantity limits that may be dispensed within a given time period. Quantities up to these maximums may be dispensed without prior approval, if all other requirements in this handbook have been met. Quantities over the designated maximums require prior approval, as described in Topic M-211.

If the attending physician has ordered a quantity that exceeds the designated maximums, the supplying provider must behave as if the higher quantity is medically necessary and must attempt to obtain prior approval for the entire order. It is not permissible for the supplying provider to dispense only the Department's maximum allowable quantity, or to dispense the full quantity and bill the patient for the items in excess of the Department's maximum allowable quantity, unless:

- The ordering physician confirms that the excess quantity is not medically necessary or
- The Department denies the request for prior approval because the excess quantity is not medically necessary.

Only in instances where the supplying provider can clearly document that items are being dispensed solely for patient convenience can the patient be charged. In such instances, the provider must inform the patient of his or her financial liability before dispensing the items.

> **Note**: Providers must contact the patient prior to dispensing each item to ensure that the patient continues to want the same provider to serve his or her medical supply needs and that the patient continues to need the items. The patient's medical eligibility must also be verified prior to dispensing.

M-210.3 TIME LIMITS

Written physician orders should reflect the expected duration of the need. Once the quantity specified by the ordering physician has been provided or the period of time on the order or the prior approval has elapsed, a new written order must be obtained. A new written order must be obtained no less than every 12 months, even for supplies needed for an ongoing chronic condition.

Prior approvals will specify the time period for which approval is being given.

In general, prior approvals for an ongoing need for medical supplies will be valid for 12 months or for the period specified in the physician's order, whichever is less.

In general, prior approvals for a medical equipment item or prosthesis will be valid for a period of six months from the approval date. If the item is not deliverable within that six month period, the supplying provider can request an extension.

M-210.4 REQUESTS FOR REPAIR

Covered equipment and prosthetic and orthotic items owned by the patient may be repaired without prior approval as long as the repair cost (per incident) does not exceed 75% of the Department's purchase price. Charges for repairs to items under warranty and repairs for which the cost will exceed 75% of the purchase price require prior approval. The frequency of repairs to certain items may be limited, with subsequent repairs requiring prior approval.

Repairs do not include modifications, technological improvements, or upgrades.

A guarantee of at least 180 days on the repair work must be provided.

Repeated requests for repair due to breakage may indicate abuse. Equipment abuse may be reported to or investigated by the Department. Verification of abuse of the equipment could result in denial of coverage for repairs.

M-210.5 REQUESTS FOR REPLACEMENT

= Replacements of covered equipment and prosthetic and orthotic items are subject to all policies that apply to an original purchase of the same item. Life expectancy of medical equipment is 4 to 5 years. In addition, a replacement will not be reimbursed by the Department for an item that is under a warranty, if that warranty will cover the necessary repairs or replacement.

If the equipment item being replaced requires prior approval and if the item was purchased by the Department for the same patient within the past 12 months, the

documentation of medical necessity for the first purchase will be deemed adequate for the replacement purchase. The request for prior approval will, however, need to include an explanation of the need for a replacement (for example, the item was lost, or has been broken beyond repair).

Repeated requests for replacement due to breakage or loss may indicate abuse. Equipment abuse may be reported to or investigated by the Department. Verification of abuse could result in denial of a replacement.

M-210.6 EQUIPMENT RENTAL LIMITATIONS

Total cumulative rental costs must not exceed the usual retail price of the medical equipment. When total cumulative rental costs meet the Department's maximum allowable purchase price, the Department considers the equipment paid for in full and the property of the patient.

Some durable medical equipment is covered on a rental basis only. Rental items are noted by an "R" in the prior approval indicator on the fee schedule. Rental charges must be terminated after the patient's need for the equipment ceases.

Rentals are considered to include all accessories and supplies needed to use the equipment.

M-210.7 LONG TERM CARE RESIDENTS SERVICE LIMITATIONS

Prior approval will not be given for residents of Long Term Care facilities for routine medical or personal care supplies or for items of equipment, when such items are considered to be the responsibility of the facility. Refer to Topic M-270 for a listing of supplies and equipment that will not normally be covered for residents of Long Term Care facilities.

For individuals with developmental disabilities residing in an Intermediate Care Facility for the Developmentally Disabled (ICF/MR), the Individual Program Plan (IPP) must support any request for non-routine items or supplies.

These limitations do not apply to residents of Supported Living (SLF) facilities. An SLF resident is considered to be residing in his or her own home for purposes of determining coverage for medical equipment and supplies.

M-210.8 HOSPITAL INPATIENT AND OUTPATIENT SERVICE LIMITATIONS

Prior approval will not be given or separate payment made for items dispensed during hospital inpatient or outpatient stays. Medical supplies and equipment, braces and prosthetic devices for use by an inpatient during hospitalization or dispensed in the hospital for continued use after hospital discharge must be

included in the hospital claim. Medical supplies and equipment or braces and prosthetic devices supplied during an APL-billable hospital outpatient visit must also be included in the hospital claim. Medical supplies and equipment or braces and prosthetic devices supplied during an APL-billable hospital outpatient visit must also be included in the hospital claim.

Certain high-technology, surgically-implantable devices require prior approval. Charges for these devices will not be separately paid and should be included in the hospital claim.

Items dispensed following hospital discharge when a patient requires a brace or prosthetic device which must be adapted for their specific needs and when that item is being delivered following inpatient discharge are covered, subject to prior approval requirements. The provider may choose to use either the date the item is fabricated or the date the item is dispensed as the date of service.

Note: If the patient is an inpatient at the time the item is fabricated and the fabrication date is selected as the date of service, charges must be included on the inpatient claim. No separate payment will be allowed in this instance.

M-210.9 HOSPICE SERVICE LIMITATIONS

Hospice is an alternative to traditional care for the terminally ill which emphasizes the reduction of pain and other symptoms of mental or physical distress and meeting the special needs of the terminally ill. If a patient has elected hospice coverage, all services related to or addressing the terminal illness are to be provided by the hospice. This includes medical equipment and supplies.

Purchase or repairs of medically necessary equipment or supplies for conditions other than the terminal illness may be covered by the Department, subject to all the policies and limitations contained in this handbook. When prior approvals are requested from the Department for supplies and equipment for a hospice patient, the prior approval request should include documentation that the hospice has denied the items because they are not related to the terminal illness.

M-211 PRIOR APPROVAL PROCESS

Prior approval is used to establish medical necessity and appropriateness for the patient's needs and to assure that quantities and charges are within allowable maximums.

Prior approval by the Department is required for the provision of all medical equipment or supplies except when the item is:

- Reimbursed by Medicare (see Topic M-213.2 for more details).
- Listed on the Department's website with an "N" indicator, denoting that no prior approval is required if the quantity dispensed is within the normal allowable quantity limits established by the Department (quantities in excess of the listed maximums do require prior approval).
- Provided for a patient who has State paid MCO (HMO) coverage, in which case the individual MCO is responsible for any approvals and payment for provision of medical supplies and equipment.
- Provided for a resident in a Long Term Care facility, in which case the Long Term Care facility is responsible (see Topic M-210.7 for more details).
- Provided for a patient receiving hospice services, in which case the hospice is responsible for provision of medical supplies and equipment related to the terminal illness (see Topic M-210.9 for more details).

Refer to Topic M-202 for instructions on obtaining a listing of covered items and prior approval requirements.

When the Department issues a prior approval notification, it specifically identifies:

- The patient
- The item or supplies approved
- The maximum quantity approved
- The time period for which the items or supplies are approved
- Whether the approval is for purchase or rental, and
- The provider.

Except for quantity dispensed, a claim submitted for payment must match the prior approval exactly or the claim will be rejected. The quantity billed may be either the same as or less than the maximum quantity approved. The time period shown on the claim must be completely within the period for which the prior approval was granted. Substitutions may not be made without contacting the Department to request a change in the prior approval.

Patients are entitled to choice of providers and may choose to change providers for rental items or ongoing supply needs. Except as noted in Topic M-211.7, the prior approval does not automatically transfer to the new provider. Either the old or the new provider must contact the Department to transfer the prior approval. The Department may request verification that the patient chose to make the change.

Prior approval does not guarantee the patient's continued medical eligibility. Payment will not be made for services provided during any period when the patient is not eligible for coverage. See Topic M-210.1 for further information.

Except as noted in this Topic, the Department's Bureau of Comprehensive Health Services is designated as the approving authority for medical equipment and supplies requiring prior or post approval consideration.

M-211.1 PRIOR APPROVAL REQUESTS

Prior approval requests must contain enough information for Department staff to make a well-informed decision on medical necessity, appropriateness and anticipated patient benefits of the item or service.

> The single most common reason for denial of prior approval requests is lack of adequate information upon which to make an informed decision.

The exact information needed will vary depending on the item requested and the medical condition of the patient, but the process described below is designed to cover the general information that is needed for all requests. Topic M-212 provides further details on the additional specific information needed for many commonly requested items. The Department's prior approval staff can assist providers in determining the specific information needed to support requests for unusual items or for items not listed in Topic M-212.

Prior approval requests may be submitted to the Department by mail, fax, telephone or electronically via the REV system.

By Mail:

The supplying provider is to complete form DPA 2240, Equipment Prior Approval Request, when requesting covered items. A sample copy of form DPA 2240 and instructions for its completion are found in Appendices M-2 and M-2a.

All forms DPA 2240 must be signed in ink by the supplying provider or his or her designee. The form DPA 2240 must be accompanied by a current signed and dated physician order for the items requested. Submitting the physician order and other necessary information and explanation of medical necessity when the initial request is made will prevent delays in processing prior approval.

By FAX:

Prior approval may be requested by fax. Complete Form DPA 2240, following the procedures described above for mailed requests. The completed form, the physician order and other associated documents can be faxed to the number shown below. Providers should review the documents before faxing to ensure that they will be legible upon receipt. Colored documents, including the pink Form DPA 2240, often do not fax clearly. The Department recommends that such documents be photocopied and that the copy be faxed.

= The fax number for prior approval requests is 217-524-0099. This fax is available Monday through Friday, 8:30 AM to 5:00 PM, excepting holidays.

By Telephone:

= When prior approval is requested by telephone, the request will be data entered by staff at the following telephone number:

1-877-782-5565 select option 5 from the automated menu

This number is available Monday through Friday, 8:30 AM to 5:00 PM, excepting holidays.

The caller must be prepared to give all the information requested on the DPA 2240.

The provider is responsible for having a valid physician order and statement of medical necessity which bears the ordering physician's signature at the time of the request. The Department reserves the right to request proof of documentation before approval is granted.

Electronically:

Prior approval requests may be electronically submitted into the Department's prior approval system by the provider via any of the Department's approved Recipient Eligibility Verification (REV) vendors. For more information on the REV system, refer to Handbook for Providers of Medical Services, Chapter 100 General Policy and Procedures, Topic 131.2. For a listing of approved REV vendors, refer to http://www.dpaillinois.com/rev/

If the provider is mailing or faxing the physician order or other medical documentation in support of an electronically-submitted request, this information should be noted in the comments section of the electronic request. In addition, the mailed or faxed materials should clearly indicate that the prior approval request has been electronically submitted. Failure to make these notations will make it more difficult for the Department to match the documentation with the prior approval request and thus may delay a decision on the request.

The Department reserves the right to request proof of a valid physician order or other supporting documentation before approval is granted.

Expedited Approvals:

= Expedited telephone approval may be obtained for items or supplies which must be delivered immediately (within 24 hours of request). Examples would include items which are needed for hospital or nursing home discharge. Expedited approval may be requested by calling the phone number listed on the previous page.

When medical supplies or rental of equipment are approved on an expedited basis, coverage will be for a maximum of one month. If the item or supplies are needed for longer than one month, continuing approval must be requested via phone, fax or mail, or electronically, as described above, and must be fully documented as described in Topic M-211.2.

M-211.2 DOCUMENTATION REQUIRED

Durable medical equipment and supplies must be specifically ordered by a physician for a specified individual. Refer to Topic M-203 for more information on physician orders. It is the responsibility of the vendor to have physician orders on file for items dispensed.

Certain items require additional specific documentation of medical need, appropriateness and ability of the patient to benefit from the item. This information must be provided at the time the request is made. Department reviewers may also request additional clarification, either from the supplying provider or from the ordering physician.

M-211.3 APPROVAL OF ITEM OR SERVICE

If the item or service requested is approved, the supplying provider and the patient will receive a computer-generated letter, form DPA 3076A, Prior Approval Notification, listing the approved items or services. Upon receipt of the Prior Approval Notification, the item(s) may be billed.

M-211.4 DENIAL OF ITEM OR SERVICE

If the item requested is denied, a computer-generated Form DPA 3076C, Notice of Decision on Request For Medical Service/Equipment, citing the denial reason, will be sent to the patient, the local DHS office and the supplying provider. The provider cannot file an appeal of the denial. If the provider obtains additional information that could result in a reversal of the denial, the provider may submit a new prior approval request with the supporting medical information attached.

M-211.5 TIMELINES

The Department is obligated to make a decision on prior approval requests within specified time frames. In general, decisions must be made within 30 days of receipt of a properly completed request, with exceptions as described below. If no decision has been made within the 30 day period, the item is automatically approved. If an item has been automatically approved, reimbursement will be made at the provider's charge or the Department's maximum rate, whichever is less.

Exceptions:

- Decisions to approve or deny requests for artificial limbs or braces must be made within 21 days after receipt of the request.
- Decisions to approve or deny requests for standard wheelchairs or hospital beds must be made within 21 days after receipt of the request.
- Decisions to approve or deny requests for medical supplies costing less than $100 must be made within 21 days after receipt of the request.

If the request is incomplete or requires further information to be properly considered, the Department may request additional information from either the supplying provider or the physician who ordered the service. If additional information is requested within 14 days of receipt of the prior approval request, the 30 day period stops. When the required information is received, a new 30 day period begins.

M-211.6 POST APPROVALS

Post approval may be requested. Post approval may be granted upon consideration of individual circumstances, such as:

- Determination of the patient's eligibility for the Medical Assistance Program or for KidCare was delayed or approval of the application had not been issued as of the date of service. In such a case, the post approval request must be received no later than 90 days following the Department's Notice of Decision approving the patient's application.

- Urgently needed equipment or supplies were provided due to a medical need which arose unexpectedly outside the Department's normal business hours, so prior approval could not be requested from the Department. In such a case, to receive an expedited decision, the post approval request must be received on the first business day after delivery of the items.
- There was a reasonable expectation that other third party resources would cover the item and those third parties denied payment after the item was supplied. To be considered under this exception, documentation that the provider billed a third party payor within six months following the date of service, as well as a copy of the denial from that third party must be supplied with the request for approval. The request for post approval must be received no later than 90 days from the date of final adjudication by the third party.
- The patient did not inform the provider of his or her eligibility for Medical Assistance or KidCare. In such a case, the post approval request must be received no later than six months following the date of service to be considered for payment. To be considered under this exception, documentation of the provider's dated, private-pay bills or collection correspondence, that were addressed and mailed to the patient each month following the date of service, must be supplied with the request for approval.

To be eligible for post approval consideration, all the normal requirements for prior approval of the item must be met and the post approval requests must be received by the Department no later than 90 days from the date services or items are provided or within the time frames identified above.

M-211.7 BOGARD CLASS MEMBERS

Pursuant to a court-ordered consent decree entered in 1993 in the class action case Bogard v DPA, et al, 88 C 2414, all eligible participants who are members of the court-approved class are assigned Individual Service Coordinators (ISCs). These ISCs are responsible for planning and coordinating all care for the Bogard class members, including obtaining necessary medical equipment and supplies. Bogard class members are generally persons over age 18 with developmental disabilities who resided in an ICF or SNF as a Medicaid recipient for a period of more than 120 days, in the aggregate, between March 23, 1986 through April 1, 1994.

When a Bogard class member has a medical need for equipment or supplies, the ISC contacts a DME provider to arrange delivery of the needed items. If the items require prior approval, the ISC will work with the DME provider to complete a Form DPA 2240, which the ISC will submit to the Department for approval.

All other policies and procedures contained in this handbook are applicable for services or items provided to Bogard class members.

M-212 LIMITATIONS AND CONSIDERATIONS ON SPECIFIC ITEMS

Certain commonly requested or highly specialized items require specific medical information for approval, as described below. This information is in addition to the basic information included on Form DPA 2240, Prior Approval Request. Limitations on the Department's coverage and related items that are considered included in the purchase or rental price of certain items are also described below.

In some instances, the Department has developed a form to guide providers to supply the needed information. In other instances, the narrative below simply describes the factors to be considered and the provider may determine the format for supplying the needed information to justify the request. In all cases, providers should refer to Topic M-211 for general guidance on requesting prior approval.

If an unusual situation exists where the medical circumstances do not fit the general models described below, but the prescribing physician feels strongly that the item is needed, providers may contact Department staff to request guidance on the types of medical information that should be submitted with the prior approval request.

M-212.1 AUGMENTATIVE COMMUNICATION DEVICES

Augmentative communication devices supplement or are alternatives to vocal communication. They are available in a continuum ranging from very simple systems, such as picture books or picture boards, to highly complex computerized systems. Such systems may also include peripherals necessary for physical or sensory access, including special input and output devices and mounting and positioning equipment.

Augmentative communication systems are considered and must be billed as durable medical equipment, Category of Service 41. The professional services related to the communication systems, e.g., assessment, therapy and follow-up and monitoring services, must be billed as speech-language therapy. Policies and procedures for speech therapy services can be found in the Handbook for Therapies. Refer to Handbook for Providers of Medical Services, Chapter 100 General Policy and Procedures, Foreword, for instructions on obtaining a copy of the Handbook for Therapies.

The determination of medical necessity for a communication device will be based on the individual's ability to communicate with a physician or principal caregiver in a manner sufficient to determine the person's care and treatment needs, to determine whether those needs have been met satisfactorily, to prevent or address an emergency medical need or to prevent or address real or foreseeable injuries or impairments.

A prior approval request for an augmentative communication device must contain the following three elements:

- A physician prescription and certification of medical necessity,
- An assessment report completed no earlier than six months prior to submission, and
- An individual treatment or implementation plan.

The Department reserves the right to request a second opinion on the medical necessity of the prescribed equipment.

Appendix M-4 provides a detailed guide to the type of information that must accompany and support a request for prior approval for an augmentative communication device. It is intended as a guide only; individual medical circumstances may require additional or different information.

When speech or occupational therapy is an integral part of the patient's adaptation to the augmentative communication device, the request for prior approval of the therapy should accompany the request for the device.

M-212.2 RESPIRATORY MANAGEMENT ITEMS

M-212.21 C-PAP or BiPAP Equipment

A prior approval request for initial rental of C-PAP equipment must support the medical need for the device and the anticipated benefits to be derived from the device. The supplying provider should obtain and submit the following documentation from the ordering physician:

- A sleep monitor study that indicates a life threatening disorder,
- Evidence that the use of the C-PAP equipment by the patient alleviated the threat to life as documented by a sleep monitoring test while the patient was using C-PAP, and
- A signed and dated physician's order for the device which includes a certification by the physician that the patient has shown the desire and ability to fully utilize the C-PAP device during sleep.

A prior approval request for initial rental of BiPAP equipment must support the medical need and anticipated benefits of the device, and in addition, must document that these benefits cannot be achieved using C-PAP equipment. The supplying provider should obtain and submit the following documentation from the ordering physician:

- A sleep monitor study that indicates a life threatening disorder,
- Evidence that the use of the C-PAP equipment by the patient did not alleviate the threat to life as documented by a sleep monitoring test while the patient

was using C-PAP, or evidence that the patient could not tolerate C-PAP,
- Evidence that the use of the BiPAP equipment by the patient did alleviate the threat to life as documented by a sleep monitoring test while the patient was using BiPAP, and
- A signed and dated physician's order for the device which includes a certification by the physician that the patient has shown the desire and ability to fully utilize the BiPAP device during sleep.

Appendix M-5 contains a facsimile of Form DPA 3701F, C-PAP/BiPAP Rental Request. This form provides a convenient format for supplying the required information, however, the Department does not require that the form itself be used if all the required medical information is supplied in another format. If the initial request fails to include all of the information described above, the Department will send a copy of Form DPA 3701F to the DME provider for completion by the attending physician. Consideration and processing of the request will be delayed pending receipt of the required information.

= Initial approvals will be for a rental for a three-month trial period. Renewals after the trial period will require a new prior approval. C-PAP and BiPAP equipment are considered purchased following ten months rental.

A request for renewal should include a signed and dated statement from the physician that:
- The patient has been compliant with the use of the C-PAP/BiPAP and with the treatment plan and that the C-PAP/BiPAP continues to relieve the patient's apnea and anoxemia,
- Provides an updated plan of care, including the anticipated duration of medical need, and
- Provides an assessment of the possible appropriateness of surgical intervention.

Copies of all follow-up sleep studies done during the trial period should also be included.

M-212.22 Oxygen Supplies and Equipment

Requests for oxygen and oxygen equipment must include measurements of arterial PO_2 or oximeter oxygen saturation. All testings must include date of the test and whether patient was receiving oxygen at the time of the test or on room air.

The physician's order must specify the O_2 liter flow rate required by the patient and the frequency of use.

If arterial PO_2 is above 55 mm Hg or arterial O_2 saturation is above 88% at rest on room air, a statement from the prescribing physician explaining the basis for medical necessity must be included with the request.

Oxygen for Long Term Care Residents

Long Term Care (LTC) facilities have the option of billing the Department directly for oxygen for their residents, or obtaining oxygen from a DME provider, with the DME provider billing the Department. If a DME provider bills for oxygen concentrators for LTC residents, prior approval is required.

Concentrators are not to be used unless the resident has an ongoing need for oxygen that requires a minimum of two liters of oxygen per minute for a minimum of 22 hours per day. The resident must have no more than an 88 percent oxygen saturation level on room air. No other method of oxygen administration (tank or liquid) is reimbursable for a resident during a month in which an oxygen concentrator is reimbursed by the Department for that same resident.

When an LTC facility obtains oxygen equipment and supplies from a DME provider, **both** providers must exercise care to ensure that the Department is not billed twice for the same service. The LTC facility is responsible for the cost of the first tank of oxygen used by a resident each month. The first tank is defined as:

- One “H” tank (6900 liters) or
- Two “E” tanks (623 liters) or
- 20 pounds of liquid oxygen.

The cost of this first tank for each resident each month may not be billed to the Department by the DME provider. The remaining tanks or refills may be billed to the Department by either the DME provider or the LTC facility, but not by both.

M-212.23 Apnea Monitors

Requests for prior approval for an apnea monitor must be accompanied by the attending physician’s evaluation of the patient’s condition, including diagnosis, evidence of apneic episodes and expected duration of the need for the monitor.

= Apnea monitors are approved for rental up to twelve months. The rental amount is to include all supplies needed for the use of the apnea monitor. These items include, but are not limited to, belts, electrodes and wires. Supply items for an apnea monitor may be approved only if the apnea monitor is owned by the patient. An apnea monitor is considered purchased after twelve months of rental.

For requests for extended rental periods or for renewal requests, the Department may require evaluation of monitor event recordings for evidence of apneic events and compliance in use of the monitor.

No payment will be allowed for pneumograms or separate respiratory event recordings provided in the home because most modern apnea monitors have the capacity to provide event recordings. These recordings can be evaluated for presence of true apneic events, as opposed to artifacts such as false alarms due to misplacement of sensors.

M-212.24 Ventilators

Ventilators are approved for rental only.

Rental of the primary ventilator includes the following items:

- In-line thermometers and temperature probes
- Battery power cables
- Spirometer valve or stick
- Fuel cells
- = Disconnect/low pressure alarm
- Circuits
- Bacteria filters
- Peep valve
- Exhalation valve
- Exhalation diaphragm
- Test lung
- Batteries
- Trach swivel adapter
- All other filters, including PALL, hydrophobic and hydroguard filters
- Drainage bags/water traps
- CO_2 monitor
- O_2 analyzer
- Respirometer
- = Cleaning Supplies (i.e., cidex, control III, vinegar)

Related items which may be provided and billed separately with proper medical documentation and prior approval are:

- Humidifier and heater
- Pulse oximeter
- Suction machine
- Compressor
- Apnea monitor
- Oxygen
- Tracheostomy tube
- Tracheostomy care/clean kits
- Suction catheters
- Ambu bag

A portable volume ventilator as a backup in case of power failure may be approved with medical documentation that the patient requires mechanical ventilation for more than 22 hours per day. Batteries and battery cables are included in the rental rate. No additional supplies or related equipment will be allowed separately as these may be transferred from the primary ventilator to the portable ventilator if it is needed.

Requests for a portable volume ventilator for any reason other than as a backup will be individually considered.

A therapeutic ventilator may be approved for patients who are able to breathe on their own but are unable to produce respirations which are strong enough and deep enough to maintain relatively normal PO_2 and PCO_2 levels.

For patients needing ventilator support for 12 hours per day or less (usually during sleep), a therapeutic ventilator may be approved with the following medical documentation of need:

- A history of hospitalizations related to the need for ventilator support,
- An explanation of circumstances or diagnoses leading to the need for a ventilator,
- PO_2 and PCO_2 levels for two successive nights, each time before putting the ventilator on the patient, and
- PO_2 and PCO_2 for the associated mornings when the ventilator is removed.

The following items are included in the rental of a therapeutic ventilator and may not be billed separately:

- Disconnect alarm and connectors
- Circuits, adapters, connectors and tubing
- Hydroguard filters
- Bacteria filters
- Swivel adapters
- Water traps
- Temperature probes

M-212.25 High Frequency Chest Compression Devices

Requests for equipment to provide high frequency chest compression will be approved for patients with cystic fibrosis when their condition has progressed to a point where manual chest compressions are no longer effective for the removal of lung secretions. Requests for conditions other than cystic fibrosis will be reviewed on an individual basis.

Initial requests should include complete diagnosis, history of hospitalizations during the past year, results of pulmonary function tests, current medications and therapy plan, and the attending physician's statement of medical necessity. Initial approvals will be given for a three to six month trial period.

Renewal requests should document patient compliance, update the therapy plan and current medications, and provide a history of hospitalizations during the trial period.

M-212.3 PROSTHETICS AND ORTHOTICS

Prosthetic and orthotic devices include corrective or supportive devices prescribed to artificially replace a missing portion of the body or to prevent or correct physical deformity or malfunction, or to support a weak or deformed portion of the body. In general, requests for prior approval of prostheses and orthoses must include extensive documentation of the functional limitations the device will address and the extent of improvement or functionality that the device is expected to provide. Although the exact details will vary depending on the device requested, a simple statement of the diagnosis is unlikely to be adequate to support the prior approval request.

M-212.31 Prosthetic Devices

The first permanent prosthetic device following an amputation will not normally be approved until a preparatory prosthesis has been used for at least six months. Most preparatory prostheses and components will be reimbursed without prior approval.

A permanent prosthetic device requires prior approval. At a minimum, the request for prior approval should contain the following information:

- Medical history, including factors which contributed to the amputation
- Date, type and reason for the amputation
- A description of the stump and its healing status, including any unusual characteristics or problems which will affect the likely success of the prosthesis
- Type of preparatory prosthesis, length of time used, patient compliance and rehabilitation with the preparatory prosthesis
- Functionality expected to be gained with the permanent prosthesis, including potential for self-care or employment
- If applicable, whether the prosthesis is for the right or left limb.

Additional information should be supplied if it supports the request for the prosthesis.

If the patient has had a preparatory prosthesis for less than six months, requests for the initial permanent prosthesis should include extensive detail on patient compliance, adjustment and rehabilitation progress with the preparatory prosthesis.

Only one prosthetic device per limb will be approved. A second device to serve as a spare or multiple devices for the same limb (for example, an artificial arm with a hook and one with a hand) will not be approved.

Requests for replacement of existing prostheses must include documentation of why the existing device no longer meets the patient's current needs and evidence that it

cannot be repaired or modified to meet those needs.

M-212.32 Orthotics

Orders for orthotics must be specific as to the item desired and the medical condition it is expected to correct. If applicable, the order must specify right, left or bilateral. Orders signed by a podiatrist will be accepted only for orthoses for the foot and ankle. All other orthotic devices must be ordered by a physician.

Custom-molded or custom-made orthoses must have a statement of medical necessity which documents why the patient's medical need cannot be met with a pre-made or custom-fitted orthotic. Devices for which the patient is measured and fitted using stock parts are considered custom-fitted, not custom-made. Unless sufficient documentation of medical need for custom-made orthotics is submitted, prior approval will be granted for less expensive, pre-made orthotics.

Stock orthopedic shoes are covered only if a brace must be attached to at least one of the shoes.

Depth inlay shoes, with or without inserts, are covered only for patients with foot ulcers, demonstrated impaired healing of the foot or toes, or a history of amputation or other serious medical foot problems due to diabetes or venous insufficiency. A simple diagnosis of diabetes is not sufficient medical justification for depth inlay shoes.

For Department consideration, a Request for Approval for Orthotic Services (Form DPA 314A) or a letter containing equivalent information must be completed, signed and dated by the ordering physician or podiatrist. The questionnaire or letter must be submitted with the supplying provider's request. Appendix M-9 contains a facsimile of Form DPA 314A.

Repairs of orthotic devices do not require prior approval or a physician or podiatrist order, as long as the cost of the repair does not exceed 75% of the cost of replacement. Modifications of orthotic devices are not considered repairs, and must have a physician or podiatrist order and prior approval.

M-212.4 WHEELCHAIRS

A wheelchair will only be considered for coverage if the patient's condition or diagnosis is such that, without a wheelchair, he or she would be confined to a bed or chair. Approval decisions are based on the equipment that is the least costly alternative to meet the patient's medical needs. Approval will not be granted for equipment to allow the patient to engage in leisure, recreational or social activities,

if this equipment is more costly than a wheelchair which meets the patient's medical needs. Requests for a second wheelchair or a backup wheelchair will be denied as not medically necessary if the patient's primary wheelchair is adequate to meet the medical need.

M-212.41 Purchase and Replacement

Requests for purchase of a basic, manual wheelchair must be accompanied by a signed physician's order for the wheelchair. The physician's order should include diagnosis, prognosis if applicable, duration of expected need, and pertinent medical and mobility limitations. The prior approval request must include the patient's measurements for the wheelchair, e.g., patient's hip width, height and weight.

Requests for the purchase of a power wheelchair require more documentation than requests for a manual wheelchair. A Questionnaire for Power Equipment Wheelchair (Form DPA 3701H) or a letter containing equivalent information must be completed, signed and dated by the ordering physician. The questionnaire or letter must be submitted with the supplying provider's request. Appendix M-6 contains a facsimile of Form DPA 3701H.

If a request for a power wheelchair is received without the necessary information, a letter will be sent to the provider requesting completion of the questionnaire by the ordering physician. Department consideration and processing will be delayed pending receipt of the completed questionnaire.

The Department's payment for any wheelchair includes all labor charges involved in fitting or measuring of the patient, assembly, delivery, set-up, patient or caregiver education on care and operation of the wheelchair, and shipping fees and taxes. Billing may be done only after the wheelchair is delivered to the patient. The provider must keep in his or her records a copy of the delivery slip, which must include the brand name, model and serial number of the wheelchair and which must be signed and dated by the individual receiving the equipment.

Wheelchairs will not normally be replaced in less than six years. Circumstances which may justify a replacement earlier include:

- The wheelchair is stolen. An official police report must be submitted with the replacement request. The request for replacement must also include a statement that the theft was not covered by auto or homeowner's insurance.
- The wheelchair is damaged or destroyed in a motor vehicle accident. An official police report must be submitted with the replacement request. The request for replacement must also include a statement that the damage was not covered by auto or homeowner's insurance.
- The wheelchair has been damaged beyond repair in some other manner.

The request for replacement must include an itemized price breakdown showing the cost to repair the wheelchair. The equipment must not be thrown away prior to the Department's decision on replacement.

- The patient's condition has changed in a way that makes the wheelchair no longer adequate to meet his or her medical needs. Examples might include dramatic changes in the patient's weight, deterioration of the patient's medical condition or a growth spurt of a child. Documentation of these changes must accompany the request for replacement.

All policies and prior approval requirements that apply to the purchase of the original wheelchair also apply to replacements.

M-212.42 Rental

All wheelchair rentals require prior approval. Wheelchair rentals are normally approved only if the patient's need is temporary and recuperative or if the patient has a medical need for a wheelchair while awaiting delivery of a customized wheelchair that has been approved for purchase.

If the patient's need is temporary and recuperative, the request should document the medical need by supplying the same basic information as described in Topic M-212.41 for a purchase. In addition, the request should specify the length of time the wheelchair is expected to be needed.

Requests for the rental of a wheelchair for the patient to use while awaiting delivery of a customized wheelchair should be made in conjunction with the request for the customized wheelchair. Approval for such requests will normally be granted for no more than three months. Rentals will not be approved if the patient owns a functional wheelchair but is awaiting the delivery of an approved replacement wheelchair.

Rentals are considered to include all accessories except a semi-reclining or full-reclining back. Basic cushions are considered included in the rental.

Rental coverage of a semi-reclining or full-reclining back require specific documentation of medical need, including a physician's order. If a rental wheelchair is converted to a purchase, the inclusion of any non-standard accessories in the purchase price is subject to specific documentation of medical need, including a physician's order.

M-212.43 Repairs

Repairs do not require a physician's order. Refer to Topic M-210.4 for prior approval requirements that apply to repairs. Requests for prior approval of a repair must include the brand name, model and serial number of the wheelchair, purchase date if known and an itemized breakdown of the repairs being done.

Replacement of items that are separately billable, such as batteries, trays, etc., are not considered repairs. Quantity limitations and prior approval requirements for replacement items are the same as for an original purchase.

Modifications to a wheelchair are not considered repairs. All modifications require prior approval. Refer to Topic M-212.44 for further information on prior approval requests for modifications.

If a loaner wheelchair is needed while the patient's own wheelchair is being repaired, and it is the usual practice of the provider to supply loaner wheelchairs, the loaner item may be provided without prior approval. The Department will allow a single payment of up to one month's rental.

If the patient resides in a Long Term Care facility, the cost of repairs will be covered by the Department only if the patient personally owns the wheelchair.

If the patient resides in an ICF/MR facility, the Department shares responsibility for payment for wheelchair repairs with the Department of Human Services (DHS). In general, if a non-custom wheelchair was purchased by DHS (or its predecessor, the Department of Mental Health and Developmental Disabilities), DHS will be responsible for the cost of repair. Repairs to a custom wheelchair or a patient-owned wheelchair that was not purchased by DHS will generally be paid by the Department. However, all requests for prior approval and claims for reimbursement of repairs must be sent to the Department. If Department staff determine that DHS is responsible for the cost, the Department will refer those claims to DHS and will advise the provider that this has occurred.

M-212.44 Customization

Non-standard components, non-standard accessories and modifications to the base of a wheelchair or to its components or accessories may be approved if medical necessity is established. Depending on the patient's condition, the need for customization may be known at the time of the initial purchase or may arise later as the patient's condition changes. A need to add standard components or accessories to a wheelchair, or a need for an unusually large or small wheelchair are not considered customization.

Requests for customization must include:

- An itemized price breakdown of all needed components, accessories and modifications
- The manufacturer's product and price information, if applicable
- A physical or occupational therapy evaluation which clearly identifies the patient's physical limitations and abilities related to the wheelchair, medical history and current medical status
- Documentation of other, less expensive options that were considered and

why those options will not meet the patient's medical need
- A physician's certification of medical necessity. Medical necessity must be documented for each component, accessory or modification as it relates to the patient's medical needs.

> **Note**: Simply describing the function of a component or accessory does not constitute adequate documentation of the patient's medical need.

This information is required in addition to the basic patient data, such as diagnosis, which is routinely required to establish medical necessity for the wheelchair.

M-212.45 Batteries

If a patient owns a power wheelchair, two batteries will be approved per year. Additional batteries require specific documentation of the unusual need. Wheelchair batteries are not considered repair items.

A wheelchair battery may be requested and approved by phone on an urgent basis if the battery is all the wheelchair needs to make it operational and if the battery can be supplied within 24 hours of the telephone call.

M-212.5 ENTERAL THERAPY

Enteral therapy prior approval requests may be submitted by mail or fax only.

Requests for enteral therapy, supplies and equipment must include the following information:
- All enteral products the patient is taking. If there is a combination, both should be listed.
- Exactly what quantity the physician has ordered: how many cans or calories needed per day. General statements of the number delivered per month will not suffice.
- How the product is being administered to the patient (by mouth, N.G. tube or G-tube) and whether by pump or gravity.
- Length of need per physician's order and whether it is expected to be permanent. Indicate whether this is the patient's only form of nutrition or a supplement.
- Patient's height and weight is required with each prior approval request.

Requests for NG tubes or G-tubes must include the frequency of change ordered by the physician.

M-212.6 INTRAVENOUS THERAPY

Requests for intravenous therapy supplies and equipment must be complete and specific, including the following information:

- All medications given must be listed by name, not category. List exactly how the drug is ordered, i.e., frequency of administration, begin and end date, and dosage for each medication. This information must be **per physician order**, not as projected by the vendor. The Department will not accept "Indefinite" on a physician's IV order.
- Route of administration. Indicate whether it is via CVP or peripheral line. Indicate whether it is Broviac, PICC, Infusaport, Groshong, subcutaneous, intramuscular, etc.
- Equipment used to infuse the medication should correlate with the route and drugs or TPN to be infused. Two pumps will be approved by exception only (for example, when TPN is administered continuously and a drug is being given intermittently). Where there are two drugs being given that are not compatible, one pump can be made sufficient by staggering dose times, flushing the IV line and making tubing changes.
- Supplies used to infuse medication should correlate with the drug and route of administration. For example, sterile gloves are not routinely needed for IV administration. CVP dressing kits for central lines contain one pair of sterile gloves. Dressing or IV site changes must be documented.
- If equipment or supplies are requested for line maintenance only, it is important to document what drugs were infused previously and when or why they may be resumed. For example, the line may be kept open as a precautionary measure when the patient is discharged from the hospital due to the possibility of a reaction or of organ rejection.

M-212.7 OTHER COMMONLY REQUESTED ITEMS

M-212.71 TENS Unit

= Requests for a TENS unit must include specific information concerning the patient's medical condition and need. If a request is received without a completed questionnaire, approval will be given for no more than a 60 day rental period. This 60 day trial period will provide time for the ordering physician to complete the TENS Unit Questionnaire. Appendix M-7 contains a facsimile of Form DPA 3701E. Approval for purchase of the TENS unit or rental beyond the initial trial period will not be made without a new prior approval request, a new physician's order and a completed and signed questionnaire.

M-212.72 Home Uterine Monitoring

Home uterine monitoring requires prior approval. Prior approval may be obtained by telephone for patients meeting all of the following criteria:

=
- Hospitalization for preterm labor at 24-36 weeks gestation (gestation of less than 24 weeks will be individually considered and may require additional information),
- Cessation of labor accomplished by administration of a tocolytic drug, and
- Discharged to home on oral or subcutaneous maintenance tocolytic therapy.

Approval may be obtained by telephone for a data recorder (code W7616) for the purpose of monitoring pregnancy-induced hypertension in the last trimester. Approval will be limited to conditions which complicate the pregnancy such as pre-eclampsia, diabetes, etc. The claim for reimbursement should reflect the last service date of the month being billed. The number of days the patient had the equipment in her possession during that month should be listed in the units/quantity field. Only dates the items are actually used are to be billed to the Department. No payment is allowed while the patient is in the hospital or absent from her home even though the equipment is still in the home.

= Approval of a parenteral infusion pump for the administration of the subcutaneous tocolytic drug and low-dose subcutaneous tocolytic infusion pump therapy may be obtained by telephone.

The physician's order and the hospital discharge summary are required for approval of a home uterine monitor, infusion pump or data recorder.

= Approval of these items will be for no more than one month rental initially. Extension of this initial rental period requires documentation of ongoing medical need. Approval for the low-dose subcutaneous tocolytic infusion pump therapy includes the cost of the drug, the pump as well as the uterine monitor.

M-212.73 Specialty Mattresses

Specialty mattress rental may be allowed for the treatment of Stage III and Stage IV decubitus ulcers for patients living at home. The mattresses may range from low to moderately high technology. They may be self-adjusting, alternating pressure or low air loss types. Very high technology mattresses are reviewed on a case by case basis.

Approval will be given for three months rental with the documentation of need completed by the physician with each request. For Department consideration, a Speciality Decubitus Mattress Questionnaire (Form DPA 3701G) or a letter providing equivalent information must be completed, signed and dated by the ordering

physician. The information from the ordering physician must be submitted with the supplying provider's prior approval request.

The same information must be updated and submitted with each request for a renewal of the rental. Requests for renewal must also include a description of the improvement, if any, that has been noted with the therapy.

Appendix M-8 contains a facsimile of Form DPA 3701G.

If a request is received without all the required information, a letter will be sent to the provider requesting completion of the questionnaire by the ordering physician. Department consideration and processing will be delayed pending receipt of the completed questionnaire.

M-212.74 Osteogenesis Bone Growth Stimulator

= Rent or purchase of a non-invasive bone growth stimulator requires prior approval. Requests must include certification of medical necessity by an orthopedic surgeon.

For treatment of a fracture or other condition of the spine, the documentation of medical necessity must include:

- The date of fracture, if applicable,
- Documentation of failed spinal fusion longer than six months, or
- Documentation of a medical need (for example, a compromised immune system) for the device to prophylactically enhance bony healing of a patient undergoing spinal fusion.

The request must also indicate that the patient does not have an implanted cardiac pacemaker or other implanted device that may be negatively affected by the bone growth stimulator. In addition, the physician must agree to provide a follow-up report to the Department after treatment is completed, describing the treatment results.

For treatment of a fracture other than a fracture of the spine, the documentation of medical necessity must include:

- The date of the fracture,
- Evidence that there has been no healing activity over a period of at least three months, validated by x-rays, and
- A description of the fracture which indicates that the fragment separation is less than one cm or less than one-half the diameter of the bone

The request must also indicate that the patient has shown compliance with previous treatment and has agreed to this treatment.

M-212.8 NOT ELSEWHERE CLASSIFIED (NEC) OR MISCELLANEOUS ITEMS

Providers are encouraged to use specific procedure codes whenever possible. However, if the provider is unable to determine a suitable code for the item requested, the appropriate NEC or Miscellaneous Code may be used.

The provider must submit the following documentation for each NEC or Miscellaneous item requested: a copy of the manufacturer's product information or literature describing the requested item, manufacturer's pricing information, quantity, size and any other relevant specifications. Handwritten product and pricing information or the DME provider's own inventory price listing are not acceptable. A copy of the provider's invoice from the manufacturer is acceptable pricing documentation.

> The information supplied must be adequate for the Department to know exactly what is being requested, to determine whether the item meets the patient's medical need and for the Department to determine what price the Department will pay for the item.

M-213 LIMITATIONS AND CONSIDERATIONS REGARDING COVERAGE OF ITEMS BY OTHER PROGRAMS

When a covered participant is eligible for the services of other agencies (State or federal), private insurance or disability compensation, etc., such resources must be used first. The provider is responsible for determining the status of a participant's coverage and third party liability prior to submitting claims to the Department.

Refer to Handbook for Providers of Medical Services, Chapter 100 General Policy and Procedures, Topic 120 for further information on third party coverage.

M-213.1 DIVISION OF SPECIALIZED CARE FOR CHILDREN (DSCC)

The Department and DSCC coordinate and adjust their respective policies to minimize duplication between the two departments. For dually eligible children, DPA and DSCC generally do not cover the same items.

To be eligible for DPA coverage, medical equipment and supplies for children who are dually eligible must meet all the requirements described in this handbook, including prior approval. Such items require a valid physician order and must meet all other coverage requirements as outlined in this handbook, regardless of their inclusion in a DSCC case plan. The DSCC case plan, however, may contain information that will assist in obtaining prior approvals from the Department, such as the medical justification for the item, functional prognosis, etc.

M-213.2 MEDICARE (CMS)

For patients with Medicare coverage, charges must be first submitted to Medicare. When billing Medicare, it is important that all secondary diagnoses be shown on the claim, even when the treatment is for an acute illness. Medicare's payment decision may be more favorable with consideration of an accompanying chronic illness.

The Department will consider Medicare's payment on an item or service to be a determination of medical necessity for the item and for the quantity dispensed and paid. Providers may bill the Department for consideration of co-insurance and deductibles on Medicare-paid items by submitting Form HCFA 1500 with a copy of the EOMB attached.

Refer to Appendix M-1b for specific instructions on billing Medicare/Medicaid combination claims.

If Medicare makes a payment on only a portion of the quantity billed, the remaining

quantity should be billed on Form DPA 2210, with a copy of the Medicare EOMB and a letter from the provider indicating the need for a Medicare override. If the quantity is over the Department's coverage limits for that item, prior approval is required.

> **Example**: If the Department allows a quantity of ten per month without prior approval, but the physician orders a quantity of fifteen per month and Medicare allows payment for only three per month, the Department will pay co-insurance on the quantity of three. Payment for the remaining twelve items per month would require prior approval.

Refer to Handbook for Providers of Medical Services, Chapter 100 General Policy and Procedures, Topic 120.1 for more information on the relationship between the Department's coverage and Medicare coverage.

Claims which have been completely denied by Medicare, and for which the provider is seeking payment, must be submitted on a Form DPA 2210. A copy of the EOMB and a letter requesting a Medicare override must be attached. Before submitting a denied claim to the Department, the provider should review the reason for Medicare's denial to determine whether submittal of the claim is indicated. In general, the provider should submit a claim to the Department for payment consideration only when the reason for Medicare's denial of payment is either:

- The patient was not eligible for Medicare benefits, or
- The service is not covered as a Medicare benefit.

In such instances, the Department is to be billed only after final adjudication of the claims by the Medicare intermediary. If the provider requested a reconsideration of Medicare's denial, the Department is not to be billed until after Medicare's reconsideration decision.

If charges are denied by Medicare for an item or service for which the Department requires prior approval, a post approval request may be submitted but it must have the Medicare EOMB attached to explain the reason for denial. Such requests must be submitted within 90 days following final adjudication by Medicare.

Appropriate and complete documentation (including a copy of Medicare's denial, reason and date of notification) must be submitted with a provider's request (Form DPA 2240), the physician's order and documentation of medical necessity. If Medicare reconsideration was requested and denied, a copy of the reconsideration decision and any correspondence should also be attached. All limitations and requirements in Chapter M-200 apply to these requests.

M-213.3 WOMEN, INFANTS AND CHILDREN PROGRAM (WIC)

Certain special formulas and nutritional supplements are covered by the Illinois Department of Public Health's WIC Program for infants (age up to 1 year), children (aged 1-5 years), and women (pregnant, lactating or six months postpartum). Participants are expected to avail themselves of WIC benefits before seeking coverage of these same items from the Department.

The Department will cover medically necessary special infant formulas not covered or approved through the WIC Program. The Department will also cover medically necessary quantities of formulas which are in excess of the amounts provided by the WIC program. The supplying provider is to submit:

- Documentation of WIC's denial, or of WIC's coverage for an amount smaller than has been prescribed,
- A current, dated, signed physician order for the requested special formula and quantity requested, and
- Documentation of the medical condition which necessitates the special formula or the quantity which exceeds the WIC allowance.

M-270 LONG TERM CARE FACILITY SERVICES

Long Term Care (LTC) facilities are required to provide medical equipment, devices and supplies commonly used in patient care as a part of the per diem reimbursement paid to the facilities by the Department.

Such items include, but are not limited, to the following:

- Adhesive Tape
- Administration Equipment/supplies for Parenteral Fluids-IV or Subcutaneous (excluding TPN solution and equipment)
- Alcohol, Alcohol Swabs, Wipes
- Antiseptics
- Aspirator Bulbs
- Atomizers
- Band-aids
- Bandages
- Bedpans and Urinals
- Blood Pressure Kits
- Body Lotion
- Brushes
- Catheters
- Combs
- Comfort Lotions and Creams
- Corn Starch
- Cotton, Cotton Balls, Swabs
- Cushions, Non-custom
- Dental Floss
- Denture Supplies
- Deodorant or Anti-perspirant
- Diabetic Testing Supplies
- Diapers, Disposable or Non-disposable
- Disinfectants
- Disposable Enemas
- Drainage Tubing and Receptacles
- Dressings
- Durable Equipment, Non-custom (e.g., walkers, wheelchairs)
- Dusting Powder
- Elbow and Heel Protectors
- Emesis Basins
- Emollients
- Enteral Therapy Equipment and Supplies
- Eye Patches
- Gauzes
- Germicides
- Hair Conditioner
- Hearing Aid Batteries
- Heat Lamps
- Hose, Non-custom
- Hot Water Bottles
- Hydrogen Peroxide
- Ice Bags
- Irrigation Solutions
- IV Poles and Supplies
- Jay Cushions
- Lubricating Jelly
- Mattress Covers
- Mouthwash
- Nail Care Supplies
- Nebulizers
- Orthotics, Non-custom (e.g., helmets, elastic braces)
- Oximeters and Oxygen Analyzers
- Oxygen and Equipment/Supplies for Oxygen Administration
- Pads (e.g., sheepskin, moleskin)
- Petroleum Jelly (e.g., Vaseline)
- Razors
- Rectal Tubes
- Restraints
- Roho Cushions
- Rubber Gloves and Finger Cots
- Sanitary Napkins and Related Items

Scissors
Shampoo, Non-prescription
Sharps Collectors
Shaving Cream
Soaps and Soap Substitutes
Suction Catheters
Suction Machine
Suppositories
Syringes and Needles
Talcum Powder
TENS Unit and Supplies
Thermometers
Tissues
Tongue Depressors
Toothbrush
Toothpaste
Towels
Trach Supplies including Trach Care Kits
Urological Supplies
Ventilators
Vinegar Douche

Prior approval to provide equipment or supply items for an LTC facility resident with an unusual need may be requested when the item is necessary for the continuous care and exclusive use of the resident. These items are typically custom made wheelchairs, braces, custom made adaptive equipment, ostomy supplies or hearing aids, but may include other items to meet special patient needs.

Items purchased by the Department for the exclusive use of an individual resident become the property of that resident. If the resident is discharged or transferred to another LTC facility, the items must accompany the resident.

Repairs to equipment owned by the LTC facility are not covered. Equipment items are considered owned by the facility, even though they were initially purchased for the exclusive use of an individual resident, if they are subsequently donated to the facility because of the resident's death or because the resident recovers sufficiently that he or she no longer needs the equipment.

Refer to Topic M-212.22 for specific coverage conditions for oxygen for LTC facility residents.

These limitations do not apply to residents of Supported Living (SLF) facilities. An SLF resident is considered to be residing in his or her own home for purposes of determining coverage for medical equipment and supplies.